STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 03 B. WING	07/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/27/11 Facility Number: 000282 Provider Number: 155755 AIM Number: 100287520 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Golden Years Homestead was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction	K0000	Ms. Kim Rhoades Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204Dear Ms. Rhoades: Please find our Plan of Correction for our Annual Life Safety Code Survey conducted in our community July 27, 2011. Our date of compliance is August 25, 2011. Please contact me if you need any further information or details. Sincerely, Dianna Holmes, MSW, HFA Administrator The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after August 25, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident rooms. The facility has a capacity of 106 and a census of 100 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/03/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=D	Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to	K0025	**This provider has smoke barriers that are constructed to provide at least a one-hour fire**	08/25/2011

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	ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Facility Engineer on 07/27/11 at 12:15 p.m., there were twenty three ceiling penetrations in the mezzanine area in the E mechanical room where the electronic equipment and components were located. Twenty of the penetrations were left unsealed. The gaps were one fourth inch or less around the conduit lines. Additionally, one of three conduit lines extending from the side wall was not provided with fire stop material. This was acknowledged by the Facility Engineer at the time of observations. 3.1-19(b)		**resistance rating in accordance with 8.3. We have smoke barriers that may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**Areas identified will be fire caulked by our contractor, Hambrock Electric. They were responsible for the installation and fire caulking. Hambrock Electric was contacted on 7/6/2011 and can commit to having the required work completed no later than 8/25/2011.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The completion of the above stated work will ensure the alleged deficient will not recur. Environmental Services will visually inspect said areas for proper completion of the work.How the corrective action(s)	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Environmental Services will visually inspect said areas for proper completion of the work.Environmental Services will monitor continued compliance through monthly visual inspections randomly X 6 months to make sure the electrical components are sealed and proper fire stop material is in place.Findings of the inspections will be reported to the Quality Assurance Committee who will determine the frequency of further audits.	
K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 sets of Chapel smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 18.3.7.6 requires doors in smoke barriers shall comply with LSC Section	K0027	**This provider has door openings in smoke barriers that have at least a 20-minute fire protection rating or are at least 1 3/4 inch thick solid bonded wood core. Doors are self-closing and rabbets, bevels or astragals are at the meeting edges.What corrective action(s) will be accomplished**	08/25/2011

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	8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect any resident in the Chapel. Findings include: Based on observation with the Facility Engineer on 07/27/11 at 2:08 p.m., the smoke barrier door set entering the Chapel had a one fourth inch gap between the doors. These smoke barrier doors lack an astragal between the doors. This was acknowledged by the Facility Engineer. 3.1-19(b)		**for those residents found to have been affected by the deficient practice?** No resident was affected by the alleged deficient practice.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**No resident was affected by the alleged deficient practice. The set of doors entering the Chapel were fitted with a fire rated door seal reducing the opening between the doors to meet the 1/8 inch requirement.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The set of doors entering the Chapel were fitted with a fire rated door seal reducing the opening between the doors to meet the 1/8 inch requirement on 7/29/2011. This measure will ensure the deficient practice will not recur. Environmental Services will monitor doors to ensure they meet the requirements.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Environmental Services will monitor doors to ensure they meet the requirements. They will complete random monthly inspections x 6	

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			months and report findings to the Quality Assurance Committee who will determine if further inspections are required.	
K0051 SS=C	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 1. Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the large basement storage room was installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect all occupants.	K0051	**This provider's fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code and records of maintenance are kept readily available.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No resident was affected by the alleged deficient practice.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**No resident was affected by the alleged deficient practice. Esco Communications has been	08/25/2011

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	Findings include: Based on an observation with the Facility Engineer on 07/27/11 at 1:48 p.m., the smoke detector in the large basement storage room was located twenty five inches from an air supply duct. The air supply duct was mounted lower then the smoke detector but the air flow was strong and could adversely affect the operation. The main fire alarm panel was located in this storage room. Measurements were provided by the Facility Engineer. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 6 of 16 manual fire alarm boxes at the neighborhood vestibule exits and the nurses' stations were readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This		contacted and is adding 3 more pull stations outside the neighborhood offices identified. These will be before the exit doors therefore will be accessible at all times. Work completion is 8/15/2011.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Esco Communications has been contacted and is adding 3 more pull stations outside the neighborhood offices identified. These will be before the exit doors therefore will be accessible at all times. Work completion is 8/15/2011 which will ensure the alleged deficient practice does not recur.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Environmental Services will visually inspect the proper completion of the required work. They will monitor proper operations of installed units randomly x 6 months. Findings will be reported to the Quality Assurance Committee who will determine the necessity for further audits.**	

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	deficient practice affects thirty seven of one hundred residents. Findings include: Based on observations with the Facility Engineer on 07/27/11 from 2:35 p.m. to 2:40 p.m., the manual fire alarm pull station at the Maple Cove, Hickory Ridge and Chestnut Place vestibule exits were not readily accessible in that the pull station was located beyond the magnetically locked exit doors and would require the use of a key fob to access the pull stations. Additional manual fire alarm pull stations are located at each nurses' station located near each vestibule exit but on occasion the nurses' station doors will be locked. This was acknowledged by the Facility Engineer at the time of observations. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to	K0144	**This provider inspects their generator weekly and exercises**	08/25/2011

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	ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Facility Engineer on 07/27/11 during a tour of the facility from 11:30 a.m. to 2:35 p.m., the only		**it under load for 30 minutes per month in accordance with NFPA 99.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No resident was affected by the alleged deficient practice.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**No resident was affected by the alleged deficient practice. MacAllister Power Systems has been contacted to add a remote emergency stop to a remote area outside the generator cabinet. This work will be completed on 8/15/2011.**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** MacAllister Power Systems has been contacted to add a remote emergency stop to a remote area outside the generator cabinet. This work will be completed on 8/15/2011. Environmental Services will visually inspect for proper completion of the required work. This permanent repair will prevent the alleged practice from recurring.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	manual stop for the emergency generator was located on the generator. The facility did not have a remote manual stop for the emergency generator. Based on an interview with the Facility Engineer at 10:30 a.m., the generator was installed in 2009. 3.1-19(b)		**into place: Environmental Services will visually inspect for proper operations of the generator during monthly inspections. Findings will be reviewed by the Quality Assurance Committee who will determine the necessity of future inspections.**	